Steps for CAP-MR/DD Provider Enrollment

Step 1: The provider agency contacts Provider Services (919-857-4017) at the Division of Medical Assistance to request a CAP-MR/DD Medicaid enrollment packet.

To become enrolled to provide services that do not require a letter of certification from the local Lead Agency or an approval letter from Program Accountability, skip to Step 4b or 4c. See CAP-MR/DD Service Matrix.

Step 2: The provider agency contacts the CAP-MR/DD Waiver Office (919-733-8256) at the Division of MH/DD/SAS to request a list of documents needed to prepare for review by the Lead Agency. Obtain the documents as indicated and prepare agency policy and procedure manual.

Step 3: The provider agency contacts the Lead Agency to schedule a local Area MH/DD/SAS Certification Review. The Lead Agency reviews the agency using certification standards prepared by the Developmental Disabilities Section of the Division of MH/DD/SAS. The provider agency submits to the Lead Agency a **copy** of the completed provider enrollment application and the agency's license, if applicable. Be sure the application contains the required signatures. Upon satisfactory completion of the certification review, the Lead Agency issues a letter of CAP-MR/DD certification for the agency, addressed to the Program Accountability Section of DMH/DD/SAS.

Step 4a: The Lead Agency sends the certification letter, a copy of the application, and a copy of the license to the Program Accountability Section of the DMH/DD/SAS (Mail Service Center 3012, Raleigh, NC 27699-3012). The provider is sent a copy of the certification letter by the local Lead Agency.

OR

Step 4b: Provider agencies not requiring certification letters from local Lead Agencies send a copy of the application and a copy of the license to the Program Accountability Section of the Division of MH/DD/SAS.

OR

Step 4c: Provider agencies not requiring certification letters from local Lead Agencies or approval letters from Program Accountability send the original application and a copy of the license to Provider Services Section at DMA. Skip to step 7.

Step 5: The Program Accountability Section reviews the information and contacts the provider agency if there are any questions. If the information is complete, the Program Accountability Section sends a letter to DMA and a copy to the provider, approving the provider agency for the requested CAP-MR/DD services.

Step 6: The provider agency submits the completed Medicaid enrollment application, copy of license/accreditation, and approval letter from the Program Accountability Section, if applicable, to the Division of Medical Assistance Provider Services at the Division of Medical Assistance (Mail Service Center 2506, Raleigh, NC 27699-2506).

Step 7: Provider Services issues a DMA provider agreement to the applying provider agency upon submission of the required documentation. The effective date of enrollment is no earlier than the first day of the month in which the completed forms are received by Provider Services.

Step 8: DMA Provider Services notifies the provider agency if the request is denied or if there are questions. If the provider agency is approved for enrollment, DMA Provider Services will:

- Assign the provider agency a provider number for the services;
- Notify the provider agency in writing of the agency's provider number and its effective date; and
- Send the provider agency a signed copy of the provider participation agreement.

Provider agencies should not begin providing CAP-MR/DD services until a CAP-MR/DD approval letter is received from DMA for the requested services and service orders are issued by the Area Program.

NORTH CAROLINA
DIVISION OF MEDICAL ASSISTANCE
APPLICATION FOR PROVIDER PARTICIPATION
Community Alternatives Program (CAP)

Provider Services 2506 Mail Service Center Raleigh, NC 27699-2506 (9l9) 857-4017

An agency desiring to provide Community Alternatives Program services to N.C. Medicaid recipients must submit the original of this application to the Provider Services unit of the Division of Medical Assistance (DMA) at the above address. The application should be completed for initial enrollment as a CAP provider, for reapplication or re-enrollment and for amending a provider agreement to add CAP services/sites or to delete services/sites the agency will no longer provide. In addition to the application, provider agencies must sign a provider participation agreement. DMA will forward the provider participation agreement to the requesting provider along with details on provider qualifications for rendering CAP services. After approval of the agreement, DMA will send written notice of the assigned provider number and the CAP services approved.

A. IDENTIFICATION OF PROVIDER AGENCY

I. Name _____Phone Number (____)_____

E-Mail address _____ Fax Number (____)_____

2. Location Address _____
(Street) (City) (State) (Zip)

3. Mailing Address _____
(Street) (City) (State) (Zip)

4. Type of application:
( ) Initial Enrollment
( ) Reapplication/Re-enrollment

Amendment to:
( ) Add New Service
( ) Add New Site
( ) Delete Service/Site

5. The agency (check one) ( ) is ( ) is not a current CAP provider.

Current CAP provider number(s): _____

B. COMMUNITY ALTERNATIVES PROGRAM SERVICES

For initial enrollment or reapplication/re-enrollment, use “X” to indicate services the provider agency will provide under each CAP Program; use “A” to add new service(s); use “D” to delete services.

1. CAP/DA (Disabled Adult) Services

( ) Adult Day Health Care
( ) Case Management
( ) Home Mobility Aids
( ) In-Home Aide Level II
( ) In-Home Aide Level III Personal Care
( ) Medicaid Medical Supplies
( ) Personal Emergency Response System (PERS)
( ) Preparation and Delivery of Meals
( ) Respite Care – In-Home
( ) Respite Care – Institutional
( ) Waiver Supplies

2. CAP/C (Disabled Children/Katie Beckett) Services

( ) Case Management
( ) CAP/C Personal Care Services
( ) Home Mobility Aids
( ) Hourly Nursing
( ) Medicaid Medical Supplies
( ) Respite Care – In-Home
( ) Respite Care – Institutional
( ) Waiver Supplies

3. CAP-MR/DD (Mentally Retarded/Developmentally Disabled) Services

( ) Adult Day Health Care
( ) Augmentative Communication Devices
( ) Case Management
( ) Crisis Stabilization
( ) Day Habilitation
( ) Developmental Day Services
( ) Environmental Accessibility Adaptations
( ) Family Training
( ) In-Home Aide Level I
( ) Interpreter
( ) Live-In Caregiver
( ) Personal Care
( ) Personal Emergency Response System (PERS)
( ) Respite Care – Institutional
( ) Respite Care – Noninstitutional Community-Based
( ) Respite Care – Noninstitutional Nursing-Based
( ) Supported Employment
( ) Supported Living
( ) Therapeutic Case Consultation
( ) Transportation
( ) Vehicle Adaptations
( ) Waiver Supplies and Equipment

4. CAP/AIDS Services

( ) Adult Day Health Care
( ) Case Management
( ) Home Mobility Aids
( ) In-Home Aide Level II
( ) In-Home Aide Level III/Personal Care
( ) Personal Emergency Response System (PERS)
( ) Preparation and Delivery of Meals
( ) Respite Care - Institutional
( ) Respite Care – In-Home (Aide Level II)
( ) Respite Care – In-Home (Nursing)
( ) Waiver Supplies

C. PROVIDER AGENCY AKNOWLEDGEMENT

I understand that the provider agency is responsible for submitting to DMA verification and documentation of its qualifications to render the CAP services indicated on this application.

D. Beginning Date Medicaid Services will be provided _____

_____
Signature of Authorized Agent for Provider Agency Date

_____
Typed or Printed Name and Title of Authorized Agent

COMMUNITY ALTERNATIVES PROGRAM FOR PERSONS WITH MENTAL RETARDATION AND OTHER/DEVELOPMENTAL DISABILITIES (CAP-MR/DD)

TYPE OF SERVICES	PROVIDER QUALIFICATIONS	DOCUMENTATION/PROOF
Adult Day Health Care	Agency certified by Division of Aging as an Adult Day Health Care Facility	Copy of certification
Augmentative Communication Devices	Local MH/DD/SAS only	NA
Case Management	Local MH/DD/SAS **OR** Designated Lead Agency	Letter of approval from DMH/DD/SAS (Program Accountability)
Crisis Stabilization	Local MH/DD/SAS **OR** provider certified by local MH/DD/SAS	Letter of approval from DMH/DD/SAS (Program Accountability)
Day Habilitation	Local MH/DD/SAS **OR** provider certified by local MH/DD/SAS	Letter of approval from DMH/DD/SAS (Program Accountability) and copy of DFS license if applicable
Developmental Day Services	Day Care programs licensed by Division of Child Development under G.S. 110 article 7 **AND** certified by local MH/DD/SAS, **OR** Day Care programs operated by NC Public School Systems **AND** certified by local MH/DD/SAS, **OR** Developmental Day Care programs licensed under 122C **AND** certified by local MH/DD/SAS	Letter of approval from DMH/DD/SAS (Program Accountability) and copy of license from Division of Child Development or DFS, if applicable
Environmental Accessibility Adaptations	Local MH/DD/SAS only	NA
Family Training	Local MH/DD/SAS **OR** provider certified by local MH/DD/SAS	Letter of approval from DMH/DD/SAS (Program Accountability)
In-Home Aide Level 1	Local MH/DD/SAS **OR** provider certified by local MH/DD/SAS **OR** agency licensed by Division of Facility Services as a Home Care agency to provide in-home aide services	Letter of approval from DMH/DD/SAS (Program Accountability) and copy of DFS license, if applicable
Interpreter	Local MH/DD/SAS **OR** provider certified by local MH/DD/SAS	Letter of approval from DMH/DD/SAS (Program Accountability)
Live-In Caregiver	Local MH/DD/SAS only	NA
Personal Care	Local MH/DD/SAS **OR** provider certified by local MH/DD/SAS **OR** agency licensed by Division of Facility Services as a Home	Letter of approval from DMH/DD/SAS (Program Accountability) and copy of DFS license, if applicable

NA = Not Applicable. DMA has necessary documentation/proof on file. Forward any required documentation/proof to DMA with application/provider agreement.

COMMUNITY ALTERNATIVES PROGRAM FOR PERSONS WITH MENTAL RETARDATION AND OTHER/DEVELOPMENTAL DISABILITIES (CAP-MR/DD)

TYPE OF SERVICES	PROVIDER QUALIFICATIONS	DOCUMENTATION/PROOF
	Care Agency to provide in-home aide services	
Personal Emergency Response System (PERS)	Agency operating or accepting responsibility for providing 24 hrs per day, 7 days per week monitoring service	Copies of: agency marketing materials; blank contract describing services; **AND** contract between the provider agency and the monitoring station if the provider agency does not operate the monitoring service
Respite Care – Institutional	State Mental Retardation Facility only	Copy of most recent DMA notice of approval as a Medicaid provider
Respite Care – Non-Institutional Community Based	Local MH/DD/SAS **OR** provider certified by local MH/DD/SAS	Letter of approval from DMH/DD/SAS (Program Accountability) and DFS license to provide respite, if applicable
Respite Care – Non-Institutional Nursing Based	Local MH/DD/SAS **OR** provider certified by local MH/DD/SAS **OR** agency licensed by Division of Facility Services as a Home Care Agency or Home Health Agency to provide nursing services	Letter of approval from DMH/DD/SAS (Program Accountability) and copy of DFS license to provide nursing, and copy of DFS license to provide respite, if applicable
Supported Employment	Local MH/DD/SAS **OR** provider certified by local MH/DD/SAS	Letter of approval from DMH/DD/SAS (Program Accountability) and copy of DFS license, if applicable
Supported Living	Local MH/DD/SAS **OR** provider certified by local MH/DD/SAS	Letter of approval from DMH/DD/SAS (Program Accountability) and copy of DFS license, if applicable
Therapeutic Case Consultation	Local MH/DD/SAS **OR** provider certified by local MH/DD/SAS **OR** agency licensed by Division of Facility Services as a Home Care Agency or Home Health Agency to provide OT, PT, or ST	Letter of approval from DMH/DD/SAS (Program Accountability) and copy of DFS license, if applicable
Transportation	Local MH/DD/SAS only	NA
Vehicle Adaptations	Local MH/DD/SAS only	NA
Waiver Supplies and Equipment	Local MH/DD/SAS only	NA

NA = Not Applicable. DMA has necessary documentation/proof on file. Forward any required documentation/proof to DMA with application/provider agreement.

Manuals for CAP-MR/DD Providers

APSM 30-1 RULES FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES- cost: $5.75

APSM 45-1 CONFIDENTIALITY MANUAL- cost: $1.50

APSM 45-2 SERVICE RECORDS MANUAL- cost: $5.00

APSM 95-2 CLIENT RIGHTS MANUAL- cost: $3.00

CAP-MR/DD MANUAL- cost: to be determined

Checks or money orders are made payable to: DIVISION OF MENTAL HEALTH
(credit cards are not accepted)

Mail payment to: DMH Training Section
3022 Mail Service Center
Raleigh, NC 27699-3022

Manuals are available free of charge on the Division of Mental Health website at:
www.dhhs.state.nc.us/mhddsas/forms/index.htm